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Technology
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NATIONAL TUBERCULOSIS ASSOCIATION

SEPTEMBER, 1955

CHRISTMAS SEALS 1955 CHRISTMAS

THE CHRISTMAS SEAL SALE

A great American tradition that continues to grow in strength and stature, the Christmas Seal sale is not only a fund-raising method but also a high point in the year-round program to inform the public of progress being made against tuberculosis.—*Clarence W. Kehoe, Director, Christmas Seal Sale Division, NTA.*

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EDITORIAL

A Great American Tradition

"The mail sale . . . it should not be necessary to point out the importance of this method of sale." This statement applies to the Christmas Seal Sale today as it did in 1917 when it was incorporated in a booklet of instructions on "Conducting the Campaign."

The Christmas Seal Sale continues to grow in strength and stature. This method of financing the voluntary tuberculosis program has been accepted by the people of this country. It is a low-pressure fund-raising method which the people prefer.

Since 1933 the Christmas Seal Sale has increased each year. The all-time high was established in 1954 with a total of $24,670,202, an increase of $781,158 over the previous year. It is worth noting that 94.8 per cent of the 1954 total was received through the mail. This means that the Christmas Seal Sale has very effective pulling power through the mails which produces not only yearly increases but also additional money to compensate for diminishing supplementary returns. It should be stressed that the Christmas Seal Sale is primarily a mail campaign.

But it is not only a fund-raising method; it is also a high point in the year round program to inform the public of progress being made against tuberculosis. The Seal Sale also gives each tuberculosis association the opportunity of telling the people about community health programs financed by Christmas Seals.

Because the Christmas Seal Sale is a democratic appeal, no pressures are exerted to make people contribute. The individual, within the privacy of his home, determines whether or not he will contribute. There is no pressure from the place of employment, no payroll deduction, no knocking at the door.

Although the actual campaign for funds is associated with the Christmas season, it is well to remember that the Seal Sale is not a "one-shot" campaign. The results can be measured within a given period but the overall planning and the relationship of the Seal Sale to the association's total activities require year-round consideration.

The Christmas Seal Sale has a rich history of volunteer participation. Since one of the major factors in any fund-raising campaign is the amount of money that must be spent for personnel, it is essential that volunteer workers be used to keep the cost of raising Seal Sale dollars to a minimum. Some paid workers, hesitating to spend time in recruiting, orienting, and supervising volunteer workers, may ask "Is the job worth the time and effort?". If the volunteer program is adequately planned and executed then the answer is a resounding "Yes".

When working with volunteers it must be remembered that individuality plays an important role. Volunteers must be treated as individuals and they must believe in and understand the association program. They must understand that the "piece" they are doing is important in the total picture. In each community the varying interests of volunteers can be used effectively on the different aspects of the Christmas Seal Sale.

Don't fail to capitalize on extensive volunteer help in your plans for the 1955 Christmas Seal Sale. Salute and recognize the importance of volunteers who play such an important part in making the Seal Sale possible.

All factors point to a successful 1955 campaign. The enthusiasm among the associations is high, orders for Christmas Seals and Bonds have established new records, and the economic situation points to a banner year. So—give all the people in your community an opportunity to contribute to a great American tradition—the Christmas Seal Sale!—*Clarence W. Kehoe, director, Christmas Seal Sale Division, NTA.*

bulletin

NATIONAL TUBERCULOSIS ASSOCIATION

VOL. 41 NO. 8

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A Look at Home Care

Since Home Care Is Already in Practice in Many Areas, Criteria Are Needed to Determine Who Should Be Treated Outside Hospitals and What Treatment Is Suitable

by Julia M. Jones, M.D.

Dr. Jones is visiting physician, Chest Service, and physician-in-charge, Home Treatment Program for Tuberculosis Patients, at Bellevue Hospital, New York, and assistant professor of medicine, College of Physicians and Surgeons, Columbia University. A graduate of Ohio State University, Dr. Jones took her medical degree at Duke University. She is a member of the American Trudeau Society, the New York County Medical Society, and the New York Academy of Medicine. Her article is a contribution from the Committee on Public and Medical Relations of the American Trudeau Society.

The increase in home treatment of tuberculosis patients in recent years has become the subject of much discussion.

Some patients have always been treated outside hospitals, either from preference or because of a shortage of available beds. The large pneumothorax clinics of the past were a form of home treatment, and many patients rested at home. When adequate treatment could be provided results were often successful, but they were less satisfactory when quality of care was compromised by inadequate facilities. Now with more effective treatment methods it is reasonable to broaden home treatment criteria if quality of medical care can be maintained.

It is no longer practical to discuss whether or not home care is a good idea, since it is already in practice in many areas. What is needed now is critical evaluation of unhospitalized patients.

Criteria Needed

Criteria are needed for selection of patients and for providing medical care suitable to individual circumstances. It must be recalled that experience with chemotherapy is still of short duration and that there are many unanswered questions regarding efficacy of treatment. In adapting chemotherapy to home treatment these limitations should be considered.

Streptomycin and isoniazid are highly effective drugs when properly administered. Isoniazid can be given by mouth and arrangements usually can be made for parenteral injection of streptomycin either by visiting nurses or in out-patient clinics. Symptomatic response is prompt, and usually accompanied by reduction in volume and infectivity of pulmonary secretions.

Present knowledge indicates that, to be effective, treatment must be prolonged to periods of a year or more and must be continuous, that streptomycin and isoniazid are best given in combination or with para-aminosalicylic acid, and that surgical treatment is often necessary.

When properly administered, these drugs are usually not dangerous, but in some cases toxic manifestation may require a change in drug regimen. Safety requires frequent careful observation of the patient, which may be difficult if the patient is treated outside the hospital. Fortunately, toxicity usually develops during early months of therapy and serious complications can be avoided if new cases are hospitalized during the preliminary treatment period.

Drug therapy is more often limited by development of bacterial resistance to the drugs administered. This resistance is encouraged when therapy is interrupted or drugs are not given in proper combination. Extra efforts must be made to insure continuance of therapy when patients are treated outside the hospital.

Patient Education Important

Adequate observation of patients receiving drug therapy requires frequent clinical and roentgenologic observation and detailed laboratory studies which are not universally available. Since drug therapy is usually dramatically effective in relieving symptoms and is apt to encourage false optimism, thorough education of the patient is important at the onset and throughout the long period during which his faithful cooperation in treatment is needed. It is difficult to achieve the same degree of understanding during brief office and clinic visits that is possible in the hospital where the patient learns from daily contacts with doctors, nurses, and other patients.

Respiratory Cripples

It must be recognized that there are advanced cases of tuberculosis which cannot be cured with the best of therapy. Under such circumstances the patient remains chronically infected and must live as a respiratory cripple. Although hospitalization can provide nothing but permanent custodial care for these patients, outside the hospital they are potentially dangerous since the fact that they are symptom free may encourage them to return to more active life in the community.

The patient at home is not necessarily ambulatory since rest treatment is often effective at home. But if the home situation makes needed rest impossible, the patient should remain in the hospital. This is a difficult question at present since reorientation is needed on the subject of rest therapy. For present purposes it suffices to say that additional benefits of rest should not be compromised in order to treat the patient at home.

As treatment methods become simpler and easier to administer, it

may be anticipated that application of treatment will become more general, with the specialist dealing only with the more complicated clinical situations. Unfortunately, past isolation of tuberculosis patients has also isolated clinical experience and knowledge which must now be widely disseminated. Medical students and residents in training need more experience and instruction regarding tuberculosis and existing knowledge must be shared by practicing physicians.

In the past hospitalization has been urged not only for the patient's benefit but also to isolate him during the infectious period. It may be asked whether drug therapy reduces the danger of contagion sufficiently to ignore this safeguard. Factual data is needed before this question can be answered with assurance. Since patients differ in infectivity, intelligence, and willingness to cooperate, cases must be considered individually. It seems wise, however, to combine drug therapy with practical precautionary measures. The patient at home should be well informed and carefully instructed as to hygienic precautions and kept under close and frequent observation. Persons living in contact with him should be examined at regular intervals.

Is Home Care Cheaper?

Since hospital care has become increasingly costly, some enthusiasm for home care is based on the assumption that it is less expensive. It is true that for the self-supporting patient, home care may be less costly than prolonged hospitalization, but when the patient must receive treatment at community expense this saving is less certain. He still requires medical and nursing care, must be housed and fed, and his family must be assisted. The burden is shifted to a multitude of agencies and it is difficult to assess total cost. Moreover, expanding out-patient programs require increased personnel. Home treatment cannot be assumed to be inexpensive until overall costs have been studied.

When the patient is hospitalized, necessary staff can be provided not only for his medical needs but also for associated services. When patients are geographically dispersed such services become difficult to provide since work of various agencies is often inadequately integrated and the treatment team, including doctors, nurses, social workers, vocational counselors, public health nurses, and recreation workers, may be too dispersed to be efficient.

It is dangerous to assume that drug therapy, the only new feature of the present treatment program, is so effective that rehabilitation can be omitted. This has neither been demonstrated nor adequately studied. It must be borne in mind that available drugs suppress bacterial growth but are not bactericidal; relapse is now less frequent following effective treatment, but relapse potentialities still exist and may be decreased by careful rehabilitation.

Socio-economic Implications

A plan for treating a patient at home must give thought to his personal sufficiency and pattern of home life. The libraries, movies, occupational therapy, and varied human contacts that serve to keep the patient occupied in the hospital may be lacking at home.

Unfortunately the simple administration of medications does not meet all the needs of the tuberculous patient; the disease is still chronic in character, requiring prolonged adjustment and carrying with it serious socio-economic implications for the patient and his family. Long experience has shown that attention to the personal needs of the patient are necessary; this cannot be achieved casually with pills or injections but requires skilled services of many persons. Provision of such services for unhospitalized patients is a challenging problem for the future.

Home treatment offers advantages for selected patients if all clinical and personal needs can be met. Family integrity can be maintained with the patient as a participating member. The successful "home treatment" patient must assume greater responsibility for his own conduct and treatment, thus avoiding attitudes of dependency which may result from prolonged institutional life. The majority are happier at home and may therefore be better patients.

But the home is not a happy one simply because one of its members is under treatment for tuberculosis. The home must be physically adequate and family relationships must be sound; these facts should be determined before the patient begins home treatment. What constitutes a satisfactory home may differ among individuals but cannot be interpreted too broadly. Since some sort of home is an obvious necessity, application of home treatment is limited for the numerous detached, homeless men who attend clinics from unsheltered living situations.

It is true that many of these patients adapt poorly to institutional life and have been an eternal treatment problem. Some have been reported to be remarkably faithful in following a program of extramural treatment, but these are exceptional cases. In general the poorly adjusted individual is a poor patient inside or outside a hospital. Further experience is needed to determine criteria for selection of patients for home treatment. Meanwhile, thoughtful consideration must be given to the clinical and personal needs of each patient.

The advisability of a period of preliminary hospitalization for new tuberculosis cases has already been mentioned. Long range plans can be formulated after doctors, social workers, and vocational advisors have evaluated individual needs. During the preliminary period of therapy close observation is possible and evidences of drug toxicity can be detected. When suitable clinical response has been made, the patient can return to a well planned home situation, equipped to meet problems as they arise.

Continuity of Supervision

Ideally he will then continue under supervision of the same staff. Later surgical therapy may be necessary and this can be performed as part of a well-integrated, continuous program of treatment. If home treatment cannot be continued under auspices

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Ohio Recalcitrants

State Legislation Passed Requiring Hospitalization Of Any Person With Tuberculosis Refusing Hospital Care Who Is Judged to Be a "Menace to the Public Health"

by James F. Bell

Judge Bell, who is on the Supreme Court of Ohio, is executive secretary of the Madison County Tuberculosis and Health Association and president of the Ohio Conference of Tuberculosis Workers. A native of London, O., he has been a practicing attorney, Common Pleas Judge for Madison County, and a special agent of the F.B.I. Judge Bell holds degrees from DePauw and Ohio State Universities.

On the night of March 14, 1955, the Speaker of the House of Representatives called his colleagues in the lower house of the Ohio General Assembly to order and announced: "The question is whether House Bill No. 127 shall pass." And he recognized Rep. Harold Oyster, the member from Washington County, a leading sponsor of the bill. Thus was touched off a heated debate that kept the House busy for an hour and a half.

Provisions of the Bill

"This bill," explained Dr. Oyster, "is to enact certain sections of the Revised Code of Ohio relative to protecting the public health from persons with communicable tuberculosis. The bill provides that the board of health of a city or a county general health district, upon the recommendation of the health commissioner thereof, may apply to the probate court of the county in which the person resides or may be found, for an order to remove to a state tuberculosis facility, any person suffering from tuberculosis in a communicable stage who has refused to enter, or absents himself from any tuberculosis hospital, against the medical advice of the medical superintendent when in the opinion of the board of health such person is a menace to the public health."

Legislators' Objections

Immediately there arose cries of "due process of law"; "we will be making criminals of sick people"; "tuberculosis is no longer a problem." (This last statement, repeated several times during the debate had a marked effect on the 40 or 50 local tuberculosis association executives who were seated that evening in the gallery of the House of Representatives.)

A co-sponsor of the bill, a former judge of the probate court, hastened to assure the lawmakers that in his opinion the procedure provided in the bill was a valid exercise of the police power and satisfied the due process requirements of the United States and Ohio constitutions. He explained that a written complaint must be filed by the board of health not only alleging that the person is suffering from tuberculosis in a communicable stage, that he is a menace to the public health and has refused to enter, or remain in, a tuberculosis hospital, but also must set forth the names of the witnesses who will prove these facts, at least one of whom must be a doctor of medicine; that notice of the filing of such complaint must be served on the person; and that a hearing shall be held by the probate judge (without the intervention of a jury) not more than three days after the return of such service.

Commitment Order

If, upon the hearing, the probate court finds the allegations of the application to be true, the court makes a commitment order committing the person to a tuberculosis facility, and a warrant for such commitment is issued to the sheriff after the court receives a notice from the medical director of the facility that a bed is available.

The bill contains several other safeguards of a person's constitutional rights. No person may be required to submit to surgery, for instance, in the facility to which he is committed without his written consent. It is provided that any time after 90 days following such commitment, the person committed may apply to the probate court for release for the reason that he is no longer suffering from tuberculosis in a communicable stage. Should such application be denied at the hearing thereon, subsequent applications can be made at 90 day intervals.

The vote was finally taken and showed 114 to 7 for passage. On April 26, 1955, the Senate of Ohio concurred in the passage of the act by a vote of 31 to 0. It was signed by the Governor on May 5, 1955, and Ohio had a compulsory hospitalization law, effective August 5, 1955.

Careful Planning

Neither the provisions of this act nor its success in the legislature were the result of accident or happenstance. Both had been carefully considered and each legislative step carefully planned. For nearly two years, J. Edwin Farmer, first as a member of the staff of the Ohio Tuberculosis and Health Association and later as legislative consultant to the association, had worked with the Legislative Committee of the Ohio association in drafting the bill.

Many meetings were held which were attended by representatives of the medical association, nurses association, bar associations, hospital superintendents, and many other interested persons and groups. Every phase of the legislation was considered and discussed, words changed here, phrases there. Indicative of the careful work done in advance of pre-

senting the matter to the Legislature is the fact that not a single word was amended either in committee or on the floor, of either house of the General Assembly.

Of equal significance is the careful groundwork laid by Mr. Farmer and his associates in the Legislature itself and with the Governor. The fact that this bill was among the first considered by the current Legislature, to which had been presented in excess of 1500 bills, is ample evidence of the effectiveness of the job done in "selling" this program to the legislators.

Legal Aspects

As a part time executive secretary of a local tuberculosis association, I was interested in the comments made by some opponents of this legislation to the effect that tuberculosis no longer presented a problem in this country and that there was no need for legislation of this kind. As a judge, however, the legal aspects of the problem took on greater signficance for me.

I was privileged to serve on the legislative committee of the Ohio Tuberculosis and Health Association during much of the time this legislation was being drafted. The constitutional aspects of the legislation were always in the forefront of my consideration.

There is no doubt in my mind that these new sections of the Ohio Code will be tested in the courts in the light of the "due process" provisions of the 14th Amendment to the United States Constitution: "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law . . ."

Statements holding that the protection of the public health falls squarely within the police power of the state are legion in the reported decisions of Ohio and other states. Yet each new exercise of the power brings the necessity for a redetermination of the applicability of the principle.

There are, no doubt, many who shrink from the thought of locking up the recalcitrant patient, who feel we should not incarcerate the ill, that we would be virtually making a criminal out of a sick person. It should be borne in mind that this legislation is aimed at the *recalcitrant* patient only. That person now in a tuberculosis hospital, patiently obeying his doctor's advice in the hope that he may soon be well and able to rejoin his family safely, has nothing to fear from legislation of this type. It does not arm the medical superintendent of the hospital with a club to be wielded over the heads of those honestly and sincerely seeking cure.

It is estimated that, at the most, this legislation will apply to 100 persons in Ohio—100 persons out of eight and one-half million. Yet it is those 100 who pose the greatest threat to the control of tuberculosis because it is in their reckless disregard of the health and safety of others that they become a menace.

Is it an unconscionable use of power to lock up 100 to protect eight and one-half million? I think the question answers itself. Even those who would arrive at another conclusion in regard to the tuberculous would probably not hesitate to approve the method of committing the mentally ill. The procedure in the Probate Court of Ohio for committing the mentally ill to a facility therefor is almost identical with that provided for committing the recalcitrant tuberculosis patient. If anything, the safeguards of constitutional liberty in regard to notice are probably greater in the latter instance than in the former. And the legality of the former procedure has long been conceded. I believe a similar result would be reached by the courts in Ohio in regard to this new law.

Situations Similar

I think one need not be legally trained to recognize the similarity between the two situations. The mentally ill may be committed to an institution not only for his own benefit but also to protect those around him from physical harm. Is there less reason for committing to an institution a public health menace who by his failure to remain hospitalized becomes a threat to everyone with whom he comes in contact?

House Bill No. 127, now Sections 339.50 ff, of the Revised Code of Ohio, was drafted with the thought of protecting to the utmost every right of the recalcitrant tuberculosis patient consistent with the protection of the public as well. I personally feel that there is no valid constitutional objection to the legislation, either in substance or procedure, and that it might well become a model for other states.

Trudeau Officers

Nine state Trudeau Sections announce election of new officers for coming year

New officers have been elected by Trudeau Sections in the following states:

Florida: president, Dr. Harold W. Johnston; vice-president, Dr. Simon D. Doff; secretary-treasurer, Dr. Howard DuBose.

Illinois: president, Dr. George C. Turner; president-elect, Dr. Ernest Teller; secretary-treasurer, Dr. George H. Vernon.

Indiana: president, Dr. Donald W. Brodie; president-elect, Dr. Stuart R. Combs; vice-president, Dr. Arvine G. Popplewell; secretary-treasurer, Dr. C. J. McIntyre.

Iowa: president, Dr. Walter Kirkendall; president-elect, Dr. Eugene B. Floersch; vice-president, Dr. Daniel F. Crowley, Jr.; secretary-treasurer, Dr. Paul M. Seebohm.

Kentucky: president, Dr. Adam Miller; vice-president, Dr. Joseph K. Newton; secretary-treasurer, Dr. E. R. Gernert.

Louisiana: president, Dr. Walter McCook; president-elect, Dr. Thomas C. Black; secretary-treasurer, Dr. Lawrence H. Strug.

Nebraska: president, Dr. Donald R. Jackson; vice-president, Dr. Max Fleishman; secretary-treasurer, Dr. L. C. Albertson.

Massachusetts: president, Dr. Edward J. Welch; vice-president, Dr. Norman J. Wilson; secretary-treasurer, Dr. Kenneth T. Bird.

Wisconsin: president, Dr. Raymond H. Evers; vice-president, Dr. Helen Dickie; secretary-treasurer, Dr. John T. Mendenhall.

1955 Christmas Seal Sale TV Film Spots

It was a Friday on the lot at Goldwyn Studios, Hollywood. An extra from the Roy Rogers set on Stage Two wandered across to Stage One to see what was going on. He watched shooting of a few scenes and was heard to remark: "Well, it doesn't make much sense as a picture, but it's got a wow of a cast!"

What he mistook for a picture that "didn't make sense" were the 1955 Christmas Seal Sale television film spots. The cast he thought was a "wow" included Academy Award winner Marlon Brando, Mona Freeman, Dorothy McGuire, and John Wayne. And he probably recognized Academy Award nominee Sam Leavitt who was handling the cinematography as deftly as he did for "A Star Is Born."

Television program directors across the country will undoubtedly be as impressed with this star line-up as the unidentified extra. They should be pleased to run these public service announcements on their stations, as well as the "miniature documentary" film spots included in this series dramatizing the benefits of Christmas Seals.

John Wayne: ". . . you never know whose life you're saving when you buy Christmas Seals . . ."

Andy has tuberculosis. In the TB hospital he's learning a new trade . . .

This TB hospital has been my home for the last six months . . .

Dorothy McGuire: ". . . this is a picture of the tubercle bacillus, the germ that causes tuberculosis . . . For self protection, for family protection, buy and use Christmas Seals . . ."

Filming the TV spots. Dr. Howard W. Bosworth, extreme right, NTA president-elect, acted as technical advisor.

Mona Freeman: ". . . ever think of how much good you can do in just a minute? That's all the time it takes to answer your Christmas Seal letter . . ."

These children have tuberculosis . . .

Jimmy Ryan was three years old when his family discovered he had tuberculosis

Marlon Brando: ". . . 10 years ago this child would have died of tuberculous meningitis. Medical research saved her life. Christmas Seals helped finance some of this research . . ."

To Guide Tuberculosis Associations
In Formulating Their Control Programs,
The NTA Has Adopted A New Statement of . . .

Principles for Programs

A streamlined statement of principles to guide tuberculosis associations in the development of programs for tuberculosis control was adopted unanimously by the Board of Directors of the National Tuberculosis Association in Milwaukee in May. The statement is the culmination of several years' work by NTA committees.

"Approved Principles for Programs of Voluntary Tuberculosis Associations" serves as a guide on the expenditure of Christmas Seal funds and embraces major current policies of the NTA concerning programs of affiliated associations. It replaces "Authorized Forms of Tuberculosis Work" as part of the Christmas Seal Contract. The full statement is on the following page.

Significance of Education

The statement emphasizes the significance of education as a primary tool of the tuberculosis association for obtaining the development and use of adequate facilities for the discovery of tuberculosis, for the treatment and restoration of the tuberculous to a productive life through rehabilitation, and for the prevention of distress and dependency among them and their families.

The new document authorizes associations to spend Christmas Seal funds for any activity which will meet a community need for tuberculosis control. It lists five specific principles for program planning as a method of qualifying for approval of a program. These principles are:

"Investigation and analysis of the facts.

"Education of the individual and the community in the significance of the facts for needed action.

"Demonstration or support of activities to prove their value or to provide solutions where services do not exist or other funds to support them are not available.

"Encouragement and support of legislative proposals and appropriations to make permanent those services necessary to the community's tuberculois and related health needs.

"Study and review to determine the effectiveness of and the need for each activity."

One of the most significant of these principles is the last, calling for continued study and review of each activity. This review, an essential part of program planning, will require conscientious efforts of local, state, and national associations to develop flexible programs to meet changing needs for tuberculosis control.

The determination for wise activities financed through Christmas Seal funds is made by local and state associations, rather than being dictated by the national association, as under "Authorized Forms of Tuberculosis Work." The new document recognizes the varying needs in different parts of the nation, and the maturity of state and local associations. They are in the best position to plan jointly the detailed program to meet local needs.

Greater Responsibility for Affiliates

In recent years the Board of Directors of the NTA has adopted a number of policies giving greater responsibility to affiliated associations. The old detailed "Authorized Forms of Tuberculosis Work" were no longer consonant with these policies. "Approved Principles for Programs of Voluntary Tuberculosis Associations" incorporates all current policies and allows for ready modification of local programs as future progress may dictate the need for modification.

In accordance with these policies, associations may expend Christmas Seal funds to finance a program in the field of other pulmonary diseases, to promote the development of official health departments and school health programs in the same manner as tuberculosis control activities. This permission comes from specific action taken by the Board of Directors on various occasions between 1950 and 1954. These policies were adopted because good tuberculosis control programs cannot be maintained without adequate health departments and school health programs. Because other pulmonary diseases must be considered in the differential diagnosis of pulmonary tuberculosis and often either predispose to tuberculosis or occur as complications in the treatment of patients, the attack on tuberculosis requires concern for all pulmonary diseases.

The new document points out that programs for tuberculosis control, for other pulmonary diseases, and for the development of health departments and school health programs are of equal status in achieving our objective.

Activities Other Than TB Control

"Authorized Forms of Tuberculosis Work" required affiliates to obtain specific approval of the Board of Directors of the NTA for expenditures of Christmas Seal funds for any activity other than tuberculosis control. In 1952 the Board of Directors changed this policy by delegating to the constituent associations the responsibility for determining when local associations may engage in generalized health education programs. Constituent associations do not need specific approval from the NTA to exercise this authority.

In 1954 the Board of Directors adopted a policy to the effect that the NTA, on request, will delegate authority to a constituent association to determine when it or any of its local affiliates may use their funds for the support of activities in addition to those already authorized which will improve the general health of the community. Certain conditions limit this authority. These are: (1) that the constituent association shall submit evidence to the NTA that it is properly organized to supervise its local affiliates in these new activities; (2) the constituent shall determine when a local association's tuberculosis control problem and resources justify the extension of its program; (3) the constituent shall determine that a specific activity has a

sound medical, public health basis; (4) the NTA will delegate such authority only on an annual basis and the constituent will also grant such authority on an annual basis; (5) the constituent shall report to the NTA the nature of each activity engaged in by either it or any of its local affiliates under this authorization, and shall report annually on the progress of such activities.

In summary, tuberculosis associations may engage in any activity in the fields of pulmonary diseases, promotion of health departments and school health programs, as well as specific tuberculosis control programs, in accordance with these new principles. In addition, any constituent association may engage in *health education* programs, and permit its local affiliates to do likewise, in connection with *any* local public health problem without obtaining prior approval from the NTA Board of Directors. Similarly it may engage in any public health *activity,* not necessarily confined to health education, after obtaining permission from the NTA Board of Directors in accordance with the provisos given above.

However, any association contemplating activity in a health field in which another national health organization is engaged must obtain approval from the national organization concerned. If the tuberculosis association contemplates becoming an *affiliate* of the other national organization as well as of the NTA, approval of the NTA Board of Directors is also required.

Approved Principles For Programs of Voluntary Tuberculosis Associations

The program of a tuberculosis association has as its objectives the education of the individual and of the community to the end that tuberculosis be prevented and adequate provision be made available for diagnosis, treatment, and rehabilitation of the tuberculous.

In achieving these objectives the voluntary tuberculosis movement is guided by policies adopted by the Board of Directors of the National Tuberculosis Association, the primary purpose of which is to achieve the prevention and control of tuberculosis. As an aid thereto, it is the policy to promote the development of official health departments and school health programs.

Tuberculosis associations are organizations of citizens voluntarily working together to achieve their objectives by concerted community action. Each association acting through its board of directors is responsible for a program planned for people and their problems. Programs are planned to stop the spread of tubercle bacilli from person to person, to prevent tuberculosis by promoting the best possible health, and to restore to health those who have developed tuberculosis. The control of tuberculosis requires the discovery of the persons spreading the disease so that the chain of infection may be broken, the persons infected so that precautions may be taken against the disease, and the persons who have the disease so that treatment may be instituted. There must be continued consideration of them through systematic recording, medical care, adequate treatment, opportunities for restoration to a productive life, and facilities for the prevention of distress and dependency among them and their families. In every phase of the tuberculosis control program there must be recognition that the cooperation of each individual must be sought and his rights and sensibilities respected.

A tuberculosis association has a responsibility for the sound development of all parts of the community's tuberculosis control program in cooperation with other official and voluntary agencies. Its participation in the total community program requires that it plan a flexible program which utilizes community experience as well as that of local, state, and national associations.

Approved principles for such a program are:

Investigation and analysis of the facts.

Education of the individual and the community in the significance of the facts for needed action.

Demonstration or support of activities to prove their value or to provide solutions where services do not exist or other funds to support them are not available.

Encouragement and support of legislative proposals and appropriations to make permanent those services necessary to the community's tuberculosis and related health needs.

Study and review to determine the effectiveness of and the need for each activity.

To fulfill its responsibility a tuberculosis association may expend Christmas Seal Sale funds to finance a program which will qualify under the principles for program planning contained herein and which will meet the need in its community for achieving the control of tuberculosis.

Christmas Seal Sale funds also may be used to finance a program in the field of other pulmonary diseases, to promote the development of official health departments and school health programs in accordance with the principles governing the use of such funds for tuberculosis control.

A tuberculosis association also may expend Christmas Seal Sale funds to finance a program in the field of generalized health education and to support activities which will improve the general health of the community when its tuberculosis control problems and resources justify the extension of its program and when authorized by a constituent association in accordance with policies adopted by the Board of Directors of the NTA.

The citizens of each community have expressed their confidence in tuberculosis associations by their voluntary support of the Christmas Seal Sale. Each member of the Board of Directors of an association is a trustee responsible for the wise expenditure of these funds according to these approved principles for programs of voluntary tuberculosis associations.

NTA Staff Changes

National office changes include a resignation and four new staff members

Recent National Tuberculosis Association staff changes include a new national office personnel administrator, a resignation and new staff member in the Christmas Seal Sale Division, and two new staff members in the Program Development Division.

Arthur Pogran, the new personnel administrator, succeeds Gerald English who has been appointed NTA Personnel and Training Division director. Mr. Pogran, who conducted a job analysis survey for the NTA earlier this year, has been chief engineer for two New York firms and registrar and personnel director for the School of Industrial Technology. He holds degrees in education and psychology from Brooklyn College and New York University and studied electrical engineering at Cornell University.

James Broughal, an associate with the Christmas Seal Sale Division since 1953, has resigned to join the research department of the Curtis Publishing Company, Philadelphia, Pa. Prior to joining the NTA, Mr. Broughal was a market analyst with the National Biscuit Company.

Lester Grey, formerly with the Student Marketing Institute, New York, has replaced Mr. Broughal. Mr. Grey's experience includes, in addition to varied duties with the Institute, an assistant professorship in business administration at Oklahoma A & M College, and instructorships in the economics departments of New Hampshire and Pennsylvania State Universities. He holds degrees from the College of Business Administration and the Graduate School of Business of Boston University.

Frank J. Gibson, former field service director for the Maryland Tuberculosis Association, has joined the NTA as an associate in the Program Development Division with responsibilities in case finding. Mr. Gibson, who served as a field representative with the Baltimore County Public Health Association before entering the tuberculosis field, studied at Long Island University and the University of Delaware.

Gerald S. English

George Williams, a field service consultant with the Pennsylvania Tuberculosis and Health Society, will take up his duties as an associate in the Program Development Division on September 15. Mr. Williams is a graduate of Syracuse University and studied at Wayne University under an NTA-sponsored fellowship. He was executive secretary of Bradford-Sullivan Counties (Pa.) Tuberculosis and Health Association before his appointment as field consultant with the Pennsylvania society.

PHS Indian Health Division Names Advisor

Peru Farver, a Choctaw Indian, has been appointed to the staff of the recently organized Division of Indian Health, United States Public Health Service, as an advisor on relations with Indian and Alaska native populations and their tribal councils.

Mr .Farver, a veteran of 45 years' service with the Bureau of Indian Affairs, was superintendent of Indian reservations for a number of years and had been in charge of tribal affairs for the Bureau.

Heads Personnel

Gerald English appointed to succeed Irving Mushlin as head of NTA Personnel and Training

Gerald S. English, personnel administrator for the Personnel and Training Division of the National Tuberculosis Association, was appointed to succeed Irving Mushlin as division director on June 1.

Mr. Mushlin resigned as of that date to become assistant to the executive director of the New York Tuberculosis and Health Association.

Mr. English joined the NTA in 1954. Previously he was affiliated with the New York City Department of Health, and had served as a welfare director with the United Nations Relief and Rehabilitation Administration, director of training for the United Seaman's Service, and liaison officer for the Extension Service on agricultural employment.

Since 1945 Mr. English has been a personnel consultant to business firms and since 1950 a lecturer on public health administration at New York University and the Columbia School of Public Health.

He is a member of the American Public Health Association, and many other professional and community organizations.

Dr. Wilson Is New Phipps Institute Head

Dr. Julius L. Wilson, director of medical education of the American Trudeau Society, succeeds Dr. Esmond R. Long as director of the Henry Phipps Institute, Philadelphia, on July 1, the date of Dr. Long's retirement. Dr. Wilson has been assistant director and director of clinics at the Institute since 1953.

A former president of the ATS, Dr. Wilson was visiting physician of the Charity Hospital of Louisiana, New Orleans, and head of the Section on Chest Disease at the Ochsner Clinic in that city before going to Philadelphia. Dr. Wilson will continue as consultant to the Bureau of Tuberculosis Control, Commonwealth of Pennsylvania.

Making Hospitals Safe

Programs to Protect Hospital Personnel from Tuberculosis Extend Case Finding, Prevent Spread of the Disease, and Constitute an Important Aspect of Tuberculosis Control

by William G. Childress, M.D.

Dr. Childress is physician in charge, division of tuberculosis, Grasslands Hospital, Valhalla, N.Y. A graduate of the University of Cincinnati College of Medicine, he has been consultant in chest diseases at St. Agnes, New Rochelle, United, White Plains, and Mt. Vernon Hospitals (N.Y.). Dr. Childress is secretary-treasurer of the American Trudeau Society. His article is a contribution from the ATS Committee on Public and Medical Relations.

In the past investigation has shown that incidence of clinical tuberculosis was higher among certain groups, namely physicians, nurses, and other hospital personnel working in close contact with active cases of tuberculosis or tuberculous infected materials, than in the general population.

Earlier it had been held that there was no hazard for persons working in tuberculosis sanatoriums or hospitals, probably because workers in the early tuberculosis institutions consisted mainly of former patients.

In more recent literature a number of reliable reports reveal that a recognizable hazard exists for those who work with tuberculosis. For instance, a higher incidence of tuberculosis has been reported in hospitals and mental institutions where segregation of patients with active disease and the employment of protective measures are not possible. Also, a number of reports have shown a higher morbidity rate for laboratory workers, medical and nursing students, and others who are frequently exposed to infection in the course of their duties.

Better Protection Needed

It is mainly by pre-employment and periodic chest X-ray examination and routine tuberculin testing that such cases are discovered. The recognition of occupational tuberculosis by the Workmen's Compensation Board emphasized the need for better protection for workers in tuberculosis. Although some confusion followed this recognition and there was a strong trend toward preventing professional and other personnel from working in tuberculosis, including those essential in proper patient care, nevertheless many responsible institutions adopted a more realistic approach in meeting and overcoming the hazard.

It has been shown that proper protective measures permit professional groups to work in tuberculosis services without undue danger. Wherever routine chest X-ray examination is done, whether among apparently healthy or unhealthy groups, tuberculosis will be discovered. Thus chest X-ray examination of personnel and patients not suspected of having tuberculosis will result in discovery of new cases and will permit proper protection for both patients and employees.

Hazard Is Limited

Because of fear of workmen's compensation costs, some hospitals have been reluctant to institute routine and periodic examinations of these groups. This is unfortunate and in many instances has prevented use of protective measures. It should be remembered that the tuberculosis hazard is limited, which suggests a high degree of native resistance to the disease. There is no need for panic or fear in a realistic approach to overcoming the limited danger that may exist.

An annual attack rate for professional groups exposed to tuberculosis revealed an over-all average rate of about 1 per 100 per annum. Although this does not seem to be an alarming rate, it has been reduced where protective measures are used. The author's observations of employees in a large general hospital service with 300 tuberculosis beds revealed a cumulative morbidity rate over a period of one to 20 years of only 1.8 per cent; thus 98.2 per cent, including employees exposed in the Tuberculosis Division and Laboratory, did not develop clinical disease. The higher rate was in the younger groups, especially student nurses and others in close contact with open cases, before the use of improved protective measures such as early diagnosis, isolation, safer nursing, and education.

Protective Program for Hospitals

A protective program for all hospitals should be designed primarily to prevent spread of tuberculosis and to control the disease among employees and patients. It will require adequate facilities, proper planning, and determination. It will require education and cooperation of physicians, employees, and patients alike. In our experience such a program, with proper equipment, planning, and cooperation, has worked admirably.

A protective program develops logically along three main lines of defense. First, detection of existing tuberculosis in employee and patient groups through pre-employment and periodic chest X-ray examination of all employees and X-ray of all patients admitted, including those not suspected of having tuberculosis. Other diagnostic procedures, such as sputum and gastric cultures and tuberculin testing may, at times, be resourceful methods of establishing a diagnosis in questionable cases.

Secondly, early isolation of infectious cases is provided, and, thirdly, protective techniques are used while patients are waiting transfer to a

tuberculosis hospital or other facility. Techniques include safer ways in nursing and the wearing of masks and gowns when working in grossly infected areas and administering directly to positive sputum cases.

When patients are transferred to a tuberculosis ward, attention should be given to separating the less from the more infectious cases to permit use of flexible techniques. Although it is important to observe hygienic measures in any area of the ward, even with negative sputum cases, strict isolation is not practical in the average tuberculosis service, and, if proper attention is given to placement in the ward and observance of simple methods of protection, strict isolation may not be necessary. Thus rigid techniques are not required except when administering to active cases, disposing of sputum, or in contact with infected materials.

Immunization

It was not until 1948 that BCG vaccination was recommended for persons with a negative tuberculin reaction working in contact with tuberculosis. The vaccine contains attenuated tubercle bacilli which provoke a mild reaction following vaccination, thereby making the person more resistant to clinical disease. It is difficult to evaluate, at this time, the degree of immunity that BCG produces.

From reports on vaccination of large segments of the population in various parts of the world, it seems to have been established beyond reasonable doubt that vaccinated groups are less likely to develop clinical disease than non-vaccinated groups. Following vaccination a positive tuberculin reaction usually develops, but this is not always true; some revert to negative after having been positive for a limited period of time.

Periodic tuberculin testing is required to determine the period of protection from vaccination, and where BCG vaccination is used it is no longer possible to determine the infection rate for those exposed, as in the past by routine tuberculin testing. In spite of the unknowns of protection from vaccination, in the author's opinion it should be used routinely as one step in a program for protection of employees.

Needless to say, hygienic living and proper nutrition, though difficult to measure, play a prominent role in resistance. It has long been advised that personnel in tuberculosis get adequate rest, recreation, and a properly balanced diet. It is important that they practice rigid personal hygiene during working hours and especially while administering to patients.

With the advent of drugs for tuberculosis it was observed that one of the early effects was a reduction in the amount of sputum. This tends, in a quantitative way, to reduce the danger. During the course of chemotherapy the organism may be less capable of multiplying in culture and in experimental animals. Such attenuated organisms may, conceivably, be less dangerous to exposed persons, although I know of no such proof. Many cases during drug treatment convert from positive to negative sputum earlier, thus reducing the danger of exposure.

Early diagnosis, isolation of open cases, protective measures, and adequate treatment resulting in earlier conversion of the sputum are important aspects in a protective program. If all hospitals adopted such a program it would extend the base of case finding, prevent spread of disease, and offer the best chance of cure for the patient.

CIO-NTA Joint X-ray Demonstration

TO emphasize to union members the value of health services, the CIO-Community Services Committee and the National Tuberculosis Association put on a joint demonstration at the June convention of the Communications Workers of America, CIO, in St. Louis. More than 800 CWA members got free chest X-rays in this mobile unit stationed outside the convention hall. Shown discussing the plans are Berkley Watterson of the CSC, New York, Francis J. Duke, Powers Products X-ray technician, and W. W. Wendt, who represented the NTA.

San Diego County's Successful NTA Anniversary Publicity Provides Helpful Tips for Other TB Associations Developing . . .

by Edith M. Lindsay, Ed.D., and Bascom Jones, Jr.

Dr. Lindsay, who recently completed a community-wide study of tuberculosis needs for the San Diego County Tuberculosis and Health Association, is an associate professor of public health at the University of California, Berkeley. Mr. Jones is director of public relations for the San Diego Association.

Publicity Techniques

The San Diego County Tuberculosis and Health Association's week-long program of activities commemorating the 50th anniversary of the National Tuberculosis Association and the organized voluntary tuberculosis movement is now history. But it is a "history" that the local association may profitably refer to repeatedly during the coming months, as it prepares for another 50-year commemoration, that of the Christmas Seal in December, 1956.

A careful appraisal of the accomplishments and failures of the week spotlights several techniques which could shortcut the work of other associations, faced with making similar plans in the future. At the same time, it highlights a number of pitfalls.

The Importance of Time

Again and again, during the planning stages for the recent week-long program, time proved to be the association's greatest hurdle. Certainly, it was shown that now is not a bit too early to begin organized thinking on the national, state, and local levels for the important golden anniversary of the Christmas Seal.

Embryological plans for the week were discussed with the president of the board, the program committee chairman, other board members, agencies in the community, the California Tuberculosis and Health Association, and the NTA. Tentative plans for a seven-day observance of the NTA's 50th anniversary were then drawn up by a member of the local staff and presented at a regular meeting of the Association's staff late in July.

From these first discussions the plan grew, and the responsibility for and implementation of the program were carried by the board. The board voted an allocation of $2500 for the week. In the final accounting, the total expenses were $1854.

The chairman of the association's program committee took direct responsibility for the total program and allocated to the various committees of the organization the working out of details. Many persons both in the association and in community agencies were involved in the planning, development, and conducting of the various events.

Reaching the Community

Plans for the week called for reaching as many persons as possible with information about tuberculosis, stressing past accomplishments, current problems, and future needs. The week was to be used as a timely opportunity to reach the community.

Letters to the mayor and the County Board of Supervisors resulted in the week of October 10-16, 1954, being officially proclaimed "Tuberculosis Week" in San Diego City and County. The proclamations paid tribute to the strides against the disease made by the NTA and its San Diego affiliate and called for renewed support on the part of citizens in the fight for eradication of tuberculosis.

Jumping the gun on the opening of the week by one day, the association entered a prize-winning 50th anniversary float in San Diego's giant "Historical Days" parade on Saturday, October 9. The float featured Ruddy Slug, a man-sized tuberculosis bug dressed as a fighter and seated in one corner of a boxing ring. Also featured on the float were a 14-foot double-barred cross and a doctor, businessman, housewife, and nurse, all volunteers of the association, representing a cross-section of the community's fighters against tuberculosis.

Activities throughout the week itself revolved around a series of programs planned and conducted by appropriate committees of the association for physicians, nurses, social workers, volunteers, and the general public. The programs ranged from luncheon and dinner meetings to a full-day institute and featured top-notch speakers.

Mass Media Coverage

Mass media coverage, with first stories being sent out more than a month in advance of the week, snowballed and reached a highpoint as the week began, with newspapers, radio, and television providing daily coverage of the activities and implications of the week.

News releases were designed to provide factual information about tuberculosis for the public, as well as spell out the needs and problems still confronting the community. Two sound-on-film spots, featuring a Hollywood starlet, were made for use on television. Mail announcements and invitations were sent to volunteers, social workers, businesses, physicians, nurses, schools, and church groups. More than 15,000 copies of the association's annual report along with a schedule of the week's activities were mailed to persons in the county who had never contributed financially or indicated interest in the tuberculosis control program.

Church Sunday, on October 10, ushered in the week. Also on Sunday, "Your Doctor Answers," a half-hour television program presented bi-weekly by the San Diego County Medical Society, devoted its program to tuberculosis and the activities of the association and featured an interview with the president of the association. A

chest physician, member of the association's board of directors, served as consultant in planning and developing the TV program.

Under the guidance of the association's Speakers' Bureau, members of local Toastmaster Clubs gave five-minute talks at various club and organization meetings throughout the county.

The Chestmobile of the San Diego County Department of Public Health was stationed in the downtown area during the entire week to X-ray the general public. On Friday, the unit was featured on a two-hour television broadcast. *San Diego's Health,* a monthly bulletin of the Department of Public Health, carried a lead article on tuberculosis and the 50th anniversary, while a health department radio show told of the association's activities.

Association Open House

The association held open house during the entire week, honoring different groups, such as volunteers on one day, nurses on another, and school personnel on still another. Vauclain Home, the tuberculosis unit of the county hospital, sponsored a two-day public open house, the first since its dedication in 1939. Small groups were escorted through the sanatorium by previously prepared student nurses. Staff members, stationed at stop points, explained the various routines, such as surgery, drug therapy, social service, and rehabilitation. An automobile company provided cars and drivers for transportation to and from Vauclain Home and the association's headquarters.

An all-day medical symposium, featuring well-known speakers on various phases of chest pathology, attracted chest specialists as well as many general practitioners, and resulted in a large number of written requests for an annual or semi-annual symposium.

Three separate meetings were held for nursing groups, one of which was designed specifically for vocational nurses. The two other nursing sessions were tuned to the role of the nurse in preventing leaves against medical advice. A session was held for local social workers to better acquaint them with problems faced by today's tuberculosis patients, while the association's board of directors held a special luncheon meeting and discussed common problems with key guests from other agencies and organizations.

Highlight of the week for the general public was a community dinner meeting. Guest speakers included Jean Hersholt, famed to radio, TV, and movie audiences as Dr. Christian, who told of the origin of the Christmas Seal, and Dr. Joseph B. Stocklen, director of tuberculosis control, Cuyahoga County health department, Cleveland, Ohio, an NTA board member. The association presented awards to nine residents of the county for outstanding services in tuberculosis control and patient services at the meeting.

Evaluation of the many activities of San Diego's "Tuberculosis Week" pinpoints a number of suggestions for the planning of future programs, which will benefit the local association and might be of value to other groups. These suggestions include:

1. Activities should be planned, coordinated, and administered by a central committee, with the power to delegate detailed planning to other groups or individuals.

2. Allow time—*plenty* of time—to adequately plan, publicize, and schedule activities.

3. Make plans *with* the specific professional groups for whom the activities are designed rather than *for* them.

4. Assure maximum interest and participation of audiences through such proven techniques as adequate question periods, "buzz" sessions, and panel-type programs.

5. Plan early for maximum use of speakers and out-of-town visitors. For example, where their schedules permit, out-of-town speakers might be used in a scheduled program during the morning and again at a noon meeting of a club in an important county community.

6. Schedule events in county areas in addition to those within the city, to reach persons who cannot attend meetings in the city.

7. Develop evaluation procedures early in order to determine the effectiveness of the event in terms of the objectives.

8. Utilize each event to obtain information from participants on the local tuberculosis needs and problems, since these individuals are on the firing-line and are often closer to the problems.

9. Pre-plan with groups involved in conducting an event, such as hostesses for open house, in order that they will be more effective in transmitting information to the public.

10. Review the various mailing lists maintained by the association, to weed out or recognize duplication of names.

11. Recognize the responsibility of initiating or continuing semi-annual or annual institutes and workshops requested as an outgrowth of an event.

NTA Provides X-rays At Physicians' Meeting

More than 1,000 physicians attending the annual meeting of the American Medical Association in Atlantic City in June got a free chest X-ray as a result of a demonstration sponsored by the National Tuberculosis Association in cooperation with the United States Public Health Service.

The X-ray service was provided at the request of the AMA Section on General Practice. Films were read by Dr. Julius L. Wilson, NTA director of Medical education.

A breakdown showed that of 1,064 doctors X-rayed 895 were negative and one was unsatisfactory; tuberculosis was suspected in 64; other chest diseases, including cancer, were suspected in 60; and cardiovascular disease was noted in 44. Only four of the TB suspects were considered probably active. The average age of the physicians was between 50 and 55.

Occupational Therapy Meeting

The 38th annual Occupational Therapy Convention will be held in San Francisco, Cal., October 25-28, at the Sheraton-Palace Hotel. Full information may be obtained from the Northern California Occupational Therapy Association, 1680 Mission St., San Francisco, Cal.

South Dakota's Sioux Indians, United With Voluntary and Official Health Agencies, Attack the Tuberculosis Enemy Through Work of the . . .

by Marvin T. Whealy

Executive Secretary
South Dakota Tuberculosis and Health Association

Cheyenne Conference

How a meeting of representatives of voluntary and official health agencies, called to deal with a specific tuberculosis control problem, can develop into a long-range joint program has been demonstrated by the work of South Dakota's Cheyenne River Tuberculosis Control Conference.

The conference was called to cope with the serious tuberculosis problem of the 34,000 Indians residing in the state, comprising about four per cent of the population. In 1953 Indians accounted for 57 per cent of the state's tuberculosis deaths; the Indian death rate of 100 per 100,000 was one of the highest in any group in the United States. Of the 1,996 cases in the Health Department register, 953 were Indians.

In 1953 the South Dakota legislature enacted H.B. 767 permitting compulsory hospitalization of persons with communicable tuberculosis and providing machinery for better tuberculosis control throughout the state. But to bring more effective control in Indian communities, where persons with active tuberculosis were permitted almost unrestricted freedom, the law had to be adopted by the Tribal Councils which have jurisdiction on Indian reservations.

Origin of Cheyenne Conference

The Cheyenne River Sioux Tribal Council decided to support a strict control program. To consider problems involved in carrying out the Council's decision and in order to develop closer working relationships between agencies concerned with tuberculosis control at the Cheyenne River reservation, a meeting was called in September, 1953, at Sioux Sanatorium, Rapid City. Representatives of the South Dakota Tuberculosis and Health Association, the Aberdeen Office of Indian Affairs, the Sioux Sanatorium, the Cheyenne River Agency, the South Dakota Health Department, and the Cheyenne River Sioux Tribal Council attended.

Agency representatives recommended greater effort to persuade active cases to accept hospitalization through exercise of authority given to the Tribal Council to "order and compel the medical examination and treatment of any person found to be afflicted with a communicable disease." They recommended use of mobile X-ray units to speed up diagnosis of suspected cases; notification to welfare workers when hospitalization was indicated, permitting prompt assistance to families; and notification of entry into or discharge from the hospital to interested divisions of the Indian Service and the state government.

Leaves Against Advice

The conference also recommended that patients who returned to the reservation from the hospital against medical advice should be notified by the Tribal Council's Law and Order Division that they must return to the hospital or face prosecution. Follow up of patients leaving against advice but not returning to the reservation was to be the responsibility of the State Department of Health.

At a second meeting, December, 1953, the conference decided to limit its activities to tuberculosis control at Cheyenne River as a pilot project, in the hope that the methods developed there might be adopted by other reservations.

The program as it stands today has evolved from a total of six conferences. The original agencies represented have been joined by representatives of the South Dakota Division of Rehabilitation, the South Dakota Department of Welfare, the Rapid City Mayor's Committee on Human Relations, and the Pennington County Health Department. In addition, representatives of the Pine Ridge Sioux Tribal Council have attended the last two meetings.

Lack of Beds a Hindrance

Concerted action by interested agencies has been hindered at times by a lack of beds. The patient load at Sioux Sanatorium which has a rated bed capacity of 123 increased from 63 at the time of the first conference meeting in 1953 to 128 in January, 1955. An additional 20 South Dakota Indians are being treated at the State Sanatorium at Sanator. S.B. 348, recently adopted by the South Dakota legislature, will permit the state to contract with the Federal Government for the care of Indian tuberculosis patients in the State Sanatorium.

Solution to the continuing problem of leaves against medical advice depends on expansion of the hospital's patient services and additional resources for dealing with social and economic, as well as medical needs of patients and their families. During most of the time the program has been in operation, the hospital has had only one resident doctor, and, although the position of medical social worker has been established, it has not been filled.

Patient Education

But the importance of education has not been overlooked, and increasing attention is being given to attitudes of patients and their understanding of the nature of tuberculosis. The fifth meeting of the conference at Rapid City in September, 1954, was planned as an educational experience for Indian reservation leaders; a tour of the sanatorium, discussion periods, and the showing of tuberculosis films were included in the program. Tentative plans have been made to continue the educa-

tional program in a workshop type conference for Indian leaders to be held on the reservation.

The following conference meeting, December, 1954, which was attended by representatives of the National Tuberculosis Association, the United States Indian Service, and the United States Public Health Service, outlined plans for a one-week education conference to be held in May at the Cheyenne River Agency.

Indian Cooperation Excellent

The conference recognizes that success of the Cheyenne River programs is due in large measure to the work of the Tribal Council and the excellent cooperation from the people on the reservation. A notable achievement is the fact that all persons who have returned to the reservation against medical advice since the inauguration of the program have re-entered the sanatorium voluntarily. The people at Cheyenne River now generally accept the need for hospitalizing persons with communicable tuberculosis.

There are hopeful signs that some features of the Cheyenne River program may be adopted by other Indian communities. In its desire to contribute to this development, the South Dakota Tuberculosis and Health Association appointed a Committee on Indian Health early in 1954; in May, Mr. Frank Ducheneaux, chairman of the Sioux Tribal Council, was elected to the SDTHA Board of Directors and was appointed to the committee. In September, 1954, Mr. Ducheneaux and the association's executive secretary attended a meeting of the NTA Committee on Tuberculosis Among American Indians to report on the work of the control conference. In another development, G. R. Ruddell, former coordinator for the Rapid City Mayor's Committee on Human Relations, joined the association staff to develop tuberculosis programs in areas with large Indian populations.

Consideration is now being given to planning a control conference for representatives of all South Dakota tribes and reservations in the fall of 1955, after the transfer of the Indian health services to the United States Public Health Service is completed.

Dr. J. Burns Amberson

Dr. Amberson

Dr. J. Burns Amberson retired July 1 from hospital and teaching posts in New York

Dr. J. Burns Amberson, former president of the National Tuberculosis Association and a Trudeau Medalist, retired July 1 as visiting physician in charge of chest service, Bellevue Hospital, attending physician, Presbyterian Hospital, New York City, and professor of medicine, College of Physicians and Surgeons, Columbia University.

Dr. John H. McClement, chief of tuberculosis service, Veterans Administration Hospital, Fort Douglas, Salt Lake City, has been named visiting physician in charge of the Bellevue chest service and associate professor of medicine at the College of Physicians and Surgeons.

World-renowned as a teacher and clinician, Dr. Amberson plans to continue in active work in clinical teaching, consultation, and investigation. He has been appointed consultant in Bellevue and Presbyterian Hospitals and has been named professor emeritus of medicine at P. and S. He will also continue as consultant in the New York State tuberculosis hospitals and the chest services of the Kingsbridge and New York VA Hospitals.

In 1942 Dr. Amberson served as president of the NTA and in 1952 he was awarded the Trudeau Medal.

ATS Issues Service Workers X-ray Statement

In reply to a request by the Advisory Committee on Case Finding of the National Conference of Tuberculosis Workers, the American Trudeau Society has issued the following statement on X-raying of individuals providing service to the public:

"Those individuals who provide direct personal service to the public should be X-rayed at the time of starting work and on a yearly basis thereafter.

"The determination of which groups of individuals are to be X-rayed such as food handlers, barbers, beauticians, and domestics should be left to the judgment of the local health authorities, as covered by state laws or local ordinances."

Milwaukee X-ray Index Aids Local Physicians

The Wisconsin Anti-Tuberculosis Association and the Milwaukee division of the American Cancer Society are co-sponsoring a central chest X-ray card index to help Milwaukee physicians in diagnosis of patients with suspicious chest conditions.

The index, to be kept at Muirdale Sanatorium, will contain information on more than 250,000 chest X-ray films taken by the Milwaukee County tuberculosis control division. Milwaukee is believed to be the second large city in the United States to have such an index.

Regional Conferences

Three regional tuberculosis conferences will be held during September. The New England Conference will take place at Portsmouth, N.H., September 12-13, the Southern Conference at Louisville, Ky., September 22-24, and the Western Conference at Boise, Idaho, September 29-October 1. The Mississippi Valley Conference will be held at Des Moines, Ia., October 13-15.

When Hospitals Use Trained Case Workers for Duties Such As Distributing Supplies, Social Workers Are Tempted to Say . . .

Please, No Pajamas!

by Virginia Heisey

Chief of Social Service, Pittsburgh Tuberculosis Sanatorium, Pittsburgh, Pa.

"Wow! Pretty expensive pajamas!" That's what one hospital administrator said when he heard that some social service departments use their professionally trained case workers to distribute pajamas to patients.

In any hospital there are many such services which do not "legitimately" fall into the classification of appropriate functions for any of the established departments—and the all too familiar refrain is "they have to be done by someone."

But should this "someone" be a social worker who has taken advanced education—whose attention should be focused on helping the person who has become ill work out his social and emotional problems?

Of course, in the majority of hospitals, social service staff does not take responsibility for all the non-casework functions such as editing patient newspapers, supplying pajamas, admitting patients, telephoning relatives with messages from patients, or transporting patients to clinics.

Then, too, there are some hospitals where admitting comes under the social service department. Very often they employ additional personnel so that the trained case worker is free to give his full time to the duties for which he is trained.

Fortunately for the social work profession, hospitals requiring non-casework duties by the social service department are in the minority. But this minority is significant enough to cause concern.

A Dual Responsibility

The problem isn't so simple that it can be answered by saying that the social worker may not have interpreted appropriate functions adequately, or that the medical administrator may not have tried to understand services that the social worker is trained to do. Both this interpretation and understanding are necessary when establishing any new hospital service, or when re-valuating the services of an existing department.

This dual responsibility is very forcibly expressed by Dr. James E. Perkins, Managing Director of the National Tuberculosis Association, in his introduction to "A Handbook on Social Services for the Tuberculosis Patient." He says:

"The utilization of social work skills in tuberculosis control has proved most effective when the employing administrator has understood clearly from the onset what he was purchasing, and when the social worker has had an equally clear understanding of fundamentals in the diagnosis and treatment of patients.

"Some projects have failed because the employer was uninformed or misinformed concerning what social work can accomplish; some because the social worker lacked understanding of the tuberculosis control program."

Obviously this is a joint responsibility and the purchase is not an inexpensive one, so the expenditure of services should be carefully planned to make the best use of the investment.

Definition of Standards

A statement of standards to be met by medical social service departments in hospitals may be found in a booklet published by the American Association of Medical Social Workers and approved by the American Hospital Association. It states: "Activities in which social service departments may appropriately engage and which should be developed in close collaboration with the medical staff and administration are:

1. Practice of social casework.
2. Participation in program planning and policy formulation within the medical institution.
3. Participation in the development of social and health programs in the community.
4. Participation in the educational program for professional personnel.
5. Social research.

Casework service to the individual patient is the primary and fundamental activity of the department. All other activities of the department depend upon sound, continuous social casework practice."

These basic services—and perhaps the non-casework services—could be undertaken by the social service department *if* it maintained a large staff. However, since most of them are understaffed (and overworked), many compromises are made when trying to carry on both types of service.

Who Provides Non-casework Services?

In answer to the question "Who will take over these non-casework services if the social service doesn't?", we must ask another: "Who took care of them before social service was part of the hospital?"

If the service was initiated by the department because of patient need, perhaps another channel could be found to which transfer of service could be made. However, if this isn't possible, it would be well to weigh carefully the long-term cost and the value of the use of professional time. Just what would happen if the particular service were dropped in favor of meeting, to a greater degree, the patients' environmental and personal difficulties which are related directly to their illness, recovery, and preservation of health?

Now—back to the "pajama game."

At first glance it would certainly seem appropriate for the social worker, in her community contacts, to assist in

locating resources for obtaining pajamas if they are not provided automatically through the hospital, or through a grant to the hospital. However, determining whether the patient needs pajamas—and distributing them to him during his hospitalization—could be handled better by the nursing staff. They see him many times daily and know whether or not he has family resources. They have access to the clothing supply and are able to provide clothing when needed.

If the case worker, in her patient contacts, learns of unexpressed needs, she can help the patient use this channel, just as the patient may learn to use other hospital and community resources.

Utilizing Community Resources

One of the basic services of the social worker is determining to what degree community resources are being used. For example, in one hospital the social worker was called on many times to help a patient with his application for a non-service-connected pension. By the time all forms and correspondence were completed, the case worker had made five contacts with the patient and his family, and four phone calls to the Veterans Administration and the State Veterans Commission.

Although this was an extremely important service to the patient, who undoubtedly was able to adjust to his hospitalization with greater ease, it was a service that could have been carried out better by a VA representative. A count of the total number of veterans in the hospital and a letter to the VA by the medical director of the hospital resulted in a weekly visit by a contact man from a nearby VA Hospital.

This example illustrates a tendency on the part of some case workers to want to take on and retain functions which could be performed elsewhere. However, social workers sometimes reason that they get to know the patient by helping him with various social problems.

Since the social service staff usually is more than busy with direct referrals from doctors, nurses, the patients themselves, community agencies, and families, we must remember that the indirect method, when practiced to a large extent, results in fewer patients seen and in lower quality of service.

What is Medical Social Work?

Just what does the medical social worker do?

Medical social service is set up within a hospital to help meet the problems of patients. It is based on the knowledge that medical needs may be caused or aggravated by social and emotional factors and that help is needed in adjustment to illness and treatment.

This may mean direct help to the patient and his family, contact with the physician or persons involved in treating the patient, work with the community agencies, or all three.

An illustration of direct help is the case of Mrs. Means who was found to have tuberculosis following a diagnosis of tuberculous meningitis in her six-month-old baby. The baby was in a children's hospital and the mother was sent to a tuberculosis hospital. Three other children in the family were sent to relatives in another state.

There were many areas of social work help in this complex situation but the main services involved helping Mrs. Means accept the medical decision that the baby could not live. The medical social worker helped her overcome her feelings of guilt from her conviction that she was responsible for the baby's illness.

Since she was afraid that the relatives could not afford to care for her other three children, she was assured that financial resources were adequate for their care. She was urged to take care of herself, since self-sacrifice for her children had been her pattern prior to her hospitalization.

Mr. Means had been imprisoned and was of no help. Mrs. Means naturally was very angry with him for leaving her alone at this difficult time and she swore she would "never have anything to do with him again."

Mrs. Means' baby did die. She was able to remain in the hospital and her husband, released from jail the day of the baby's death, was able to take over complete responsibility for funeral arrangements. She said later that she had been able to see through this most difficult time of her life mainly because she had had an opportunity to talk out her problems and carry out her plans through the help of the social worker.

The medical social worker had 12 interviews with the patient, kept the medical staff aware of the patient's situation, and had numerous contacts with social service at the childrens' hospital. The worker also contacted the jail regarding the husband's release, had joint interviews with the patient and her husband, and, at their request, made a referral to a family agency to try to work out a plan to bring the children back to their home.

A complex situation? Yes. An extreme example? Perhaps. But an example that illustrates full use of the training of the medical social worker, expensive, time-consuming training and education that should not be "frittered" away distributing pajamas.

When specialized training and professional "know-how" are lost in a maze of non-casework duties, a social worker's job can be one of indignation, procrastination, and frustration. But a properly functioning social worker's job is fascinating and rewarding.

California Program Shows Value of Prison X-rays

The importance of X-raying prisoners has been demonstrated by the X-ray program at the Contra Costa (Cal.) County Jail, sponsored by the Contra Costa Tuberculosis and Health Association, the Health Department, and the Jail.

According to figures released by Dr. C. J. Pertuit, association president, during the first six months of the program X-rays were taken of 2,144 prisoners, approximately 96 per cent of all prisoners booked. Seven new cases of active tuberculosis and four other probably active cases were found. More than five per cent of all prisoners X-rayed showed evidence of suspected tuberculosis.

Dr. Pertuit commented that a comparable number of X-rays among the general population could be expected to find not more than two active cases. The jail program will continue on a demonstration basis until December 31.

BrooklynExecutive

Nelson Kraemer, executive director Mass. TB League, named to fill Brooklyn post

Nelson R. Kraemer, executive director of the Massachusetts Tuberculosis and Health League and former director of the Christmas Seal Sale Division of the National Tuberculosis Association, has been appointed Managing Director of the Brooklyn Tuberculosis and Health Association.

Mr. Kraemer joined the NTA in 1949 after wartime overseas service with the American Red Cross and after serving as executive director of the North Hudson, N.J., chapter of the Red Cross and as executive director of the Hudson County, N.J., Tuberculosis League. In 1952 he left the NTA to become director of the Massachusetts Tuberculosis League.

A native of New Jersey, Mr. Kraemer is a graduate of New York University and did post-graduate work at Columbia University. He is a member of the American Public Health Association.

Mr. Kraemer, who will take up his new duties in September, is filling the post left vacant by the death of Dr. Charles S. Prest last November.

Nelson R. Kraemer

Home Care

. . . *Continued from page* 116

of the hospital in which treatment began, then an effort should be made to transfer detailed information and plans to the patient's private or clinic physicians and social workers.

The hospital plays a continuing but selective part in treatment of such patients. Its services are needed for new cases, for the clinically ill, and for specialized services such as thoracic surgery. The asymptomatic patient on prolonged drug therapy and the convalescent patient under continuing clinic supervision can release beds to the acutely ill if suitable arrangements can be made for their treatment at home.

Much is to be gained from sharing experience in a period of change. Community problems differ and various adaptations are successful under differing circumstances. In subsequent articles information from various parts of the country where home treatment programs are in progress will be shared. Such information should contribute to our understanding of some of the questions which have been posed regarding home treatment of tuberculosis.

Fitzsimons Hospital Symposium

The Eighth Annual Symposium on Pulmonary Diseases will be held at Fitzsimons Army Hospital, Denver, Colo., September 26-30, under sponsorship of the hospital, the University of Colorado School of Medicine, and the American Trudeau Society. Registration for the course is limited to 300 physicians in private practice, government service, and the armed forces.

NTA Researchers To Meet

Investigators receiving medical research grants from the National Tuberculosis Association for work related to immunology in tuberculosis will meet with members of the Committee on Medical Research of the NTA's medical section, the American Trudeau Society, October 18 at the Henry Hudson Hotel, New York City.

BOOKS

The following book may be purchased through The Bulletin at the price listed:

TAKING HOLD OF TELEVISION

by Robert S. Hall. A guide for health, welfare, and civic organizations published by the National Publicity Council for Health and Welfare Services, 257 4th Ave., New York 10, N. Y. Hard cover, 119 pages, 1954. Price $2.00.

Here is a book designed for health and welfare groups facing the problem of "taking hold of television" as a means of interpreting their story to the public. The book is a practical, down-to-earth guide covering important phases of the subject, from how organizations can approach this medium to inexpensive ways of preparing both spot announcements and programs.

TUBERCULOSIS IN CHILDHOOD AND ADOLESCENCE

by F. J. Bentley, M.D., F.R.C.P., D.P.H. senior physician, High Wood Hospital for Children, Brentwood, Essex, England; S. Grzybowski, M.D., M.R.C.P., Senior Registrar, High Wood Hospital; and B. Benjamin, B.S., F.I.A., formerly statistician, London County Council; preface by Sir Robert A. Young, C.B.E. M.D., F.R.C.P., and foreword by Wilfrid Sheldon, C.V.O., M.D., F.R.C.P. Published by the National Association for the Prevention of Tuberculosis, Tavistock House North, Tavistock Square, London, WC1, England. Hard cover, 272 pages, illustrated, 1954. Price $5.00.

This monograph is recommended to those interested in the diagnosis and prognosis of tuberculosis in children.

CULTURAL DIFFERENCE AND MEDICAL CARE

by Lyle Saunders. Published by the Russell Sage Foundation, 505 Park Avenue, New York 22, N.Y. Hard cover, 317 pages with index, 1954. Price, if purchased through the Bulletin, $4.50.

This book should be studied by all who are giving medical care or supplying health services to Spanish-speaking persons or any other group which suffers cultural isolation in a community. If a health worker is to be effective with groups other than his own, an understanding of cultural differences is essential. This very readable volume fills a long-felt need.

PEOPLE

Edward T. Fagan, president of the NTA and treasurer of the Brooklyn Tuberculosis and Health Association, received the Namm-Loeser "Brooklyn Personality of the Week" award on his return from the Paris meeting of the International Union Against Tuberculosis.

Dr. Robert E. Plunkett, assistant commissioner for tuberculosis control in the New York State Department of Health, has received the Charles Evans Hughes Award of the Capital District Chapter of the American Society for Public Administration in recognition of his outstanding work in tuberculosis control.

The following officers have been elected by the Tuberculosis and Health Society of St. Louis: president, **Walter L. Metcalfe;** first vice-president, **Henry L. Langenberg;** seccond vice-president, **Mrs. Harry S. Kramer, Jr.;** and third vice-president, **Peter Husch. William D. Walsh, Walter E. Burtelow,** and **Dr. I. J. Flance** were re-elected treasurer, assistant treasurer, and medical director, respectively.

Dr. C. Howard Witmer has been re-elected president of the Pennsylvania Tuberculosis and Health Society; other officers of the Society are: first vice-president, **Freas B. Snyder,** second vice-president, **Dr. John S. Packard,** secretary, **Mrs. Catherine B. Bauer,** and treasurer, **Harold W. Wallgren.**

Glenn V. Armstrong, a past president of the National Conference of Tuberculosis Workers and former executive secretary of the Los Angeles County Tuberculosis and Health Association, died August 2.

Dr. Giles F. Filley, former director of the Physiology Department, Trudeau-Saranac Institute, Trudeau, N.Y., joined the Department of Medicine, University of Colorado Medical Center, Denver, September 1. Dr. Filley will also serve as clinical physiologist at the Colorado Foundation for Research in Tuberculosis.

Eric J. Smith has been elected president of the Los Angeles County Tuberculosis and Health Association, succeeding **Mrs. Herbert W. Sunday.** Other Los Angeles County officers are: president-elect, **Dr. C. Morley Sellery;** vice-president, **Mrs. A. W. Warnock;** secretary, **Gerald Rosen;** treasurer, **Sherman Asche.**

Norbert Reinstein, program director of the Tuberculosis and Health Society of Wayne County (Detroit), Mich., has resigned to become secretary of the Health Federation of the United Community Services of Metropolitan Detroit.

Mrs. Betty Gardner, R.N., has been re-elected president of the Maine Conference of Tuberculosis Workers.

Mrs. Lillian Christensen Griffith, formerly with the public relations staff of CARE, has been appointed director of public relations for the New York Tuberculosis and Health Association to replace **Mrs. Harold Holand** who has resigned.

New officers of the Philadelphia Tuberculosis and Health Association are: president, **Dr. David A. Cooper;** first vice-president, **Dr. Burgess L. Gordon;** second vice-president, **Dr. J. Antrim Crellin;** treasurer, **J. Hamilton Cheston;** and secretary and assistant treasurer, **Frederick R. Drayton.**

Miss Grace Bulman, director, Veterans Administration dietetic service, has received the VA Exceptional Service Award.

Dr. William H. F. Warthen, a member of the board of the Maryland Tuberculosis Association, has been elected president for 1956 of the Maryland Medical and Chirurgical Faculty.

New officers of the Vermont Tuberculosis and Health Association are: president, **Dr. R. J. McKay;** first vice-president, **Allan J. Heath;** assistant treasurer, **John T. Carpenter. Dr. Robert P. Smith, Dudley H. Davis,** and **Harold W. Slocum** were re-elected second vice-president, treasurer, and clerk respectively.

Miss Sara Sproles, former executive secretary, Anderson County (S.C.) Tuberculosis Association, has been appointed executive secretary of the Staten Island (N.Y.) Tuberculosis Committee.

Miss Martha E. Morkin, R.N,. has retired as executive secretary of the Eastern Northampton County (Pa.) Tuberculosis and Health Society after 22 years of service. Miss Morkin's successor is **Burt Sheean.**

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